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Initial assessment of patients with putative functional disorders in medical settings

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ABSTRACT

Patients presenting with symptoms suggestive of functional disorder are very frequent in practice. While it is always necessary to exclude treatable organic pathology, there are important clues in the presentation that can help the clinician. In particular, it is important to identify pathological health anxiety early in assessment, as failure to do so may lead to unnecessary investigations and the dangerous path of reinforcing reassurance. Because full assessment of functional symptoms takes time, it is suggested that a clinical support nurse with some training in psychological management should be available to guide the management of the patients with these disorders. Such support nurses, based in the clinic, offer a seamless way of providing care that is not achieved by external referral to psychologists or equivalent staff.

KEYWORDS: functional disorders, assessment, support nurses

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Introduction

Other papers in this series describe specific groups of functional disorders in specific clinics. Here, we give general guidance for these disorders in all medical settings. Taking all functional disorders together is necessary as, in many cases, multiple organ systems are involved, and often patients will be referred to several different clinics over the course of time. Identification of a functional component to a disorder is not always easy and mistakes can be made, as illustrated by one of the articles in this series. But physicians need to be aware that about half of all patients presenting at hospital clinics have at least some symptoms of a functional disorder and skill is needed to separate these symptoms from those of established pathology.[1] At one level, is not difficult to identify those who are likely to have functional disorders when they present in medical settings. These people describe their symptoms in great detail, give their complete course with remissions and exacerbations, and often have to be interrupted before they have finished, as by then the allotted interview time is running out. To evaluate these people adequately needs time, and there is a tendency in busy clinics to shorten assessment, send for investigations even if physical examination is negative, and then hope that reassurance afterwards will be sufficient. This article explains why this approach does not usually go well.

It is first necessary to establish which type of functional disorder is present. Psychiatric classifications have had difficulty in organising these disorders into meaningful groups, but currently two main categories are identified: health anxiety, in which there is excessive anxiety about having, or developing, a serious disease; and bodily distress disorder, in which the patient complains of several, often multiple, persistent medically unexplained symptoms, affecting every organ system, leading to significant distress or impairment, often with very frequent contact with health providers.[1–3] These disorders are going to be in the new *International Statistical Classification of Diseases and Related Health Problems* (ICD-11), already published online but not used formally until 01 January 2022.[4] These conditions overlap with each other, and also with anxiety and depressive disorders, but there is merit in making the distinction between them.

The big difference between these two groups is that those who have health anxiety predominantly have the fear of disease whereas those with somatic symptom disorder are concerned primarily with the removal of unpleasant symptoms. The strategies for dealing with these are very different and so early assessment is vital.

Initial assessment of referral letters

Most physicians will have a good idea of the presence of a functional disorder from the referral letter from primary care (or from a colleague in secondary care). Such letters will be couched in phrases that can easily be deciphered as 'medically unexplained symptoms' (key words in italics).

- 'I have discussed with the patient that as *these varied symptoms* do not follow a clear pattern of organic disease.'
- '[This patient] has a cluster of very *varied and possibly unrelated symptoms, alongside a number of normal investigations*. I have agreed to seek your expert opinion for the patient's reassurance.'
- 'The patient is open to the suggestion that these *non-specific and subjective neurological symptoms* may be related to the stress he experiences at work.'

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> 'We have explored the possibility of a *diagnosis of chronic fatigue syndrome* and would be grateful for your input into her care.'

We argue here that these letters should be screened by a clinical support nurse, someone who is both 'psychologically minded' and trained to some extent in psychological therapies. In our own research, we have found that general and specialised nurses in medical clinics can be trained to both identify and treat these patients, particularly if they have health anxiety.[5] In this role, they are accepted to be better than psychologists. The standard approach in current practice in the UK is to refer such patients to Improved Access to Psychological Therapies services (IAPT). This is not wise. IAPT therapists, at their present level of training, are not competent at treating health anxiety or other functional disorders, and are not able to treat these patients successfully; support nurses in clinics certainly are. This is not because they are necessarily more competent, but that they are considered more credible therapists. In a recent long-term evaluation of a randomised controlled trial of cognitive behavioural therapy in health anxiety, those treated by nurses more than doubled remission from pathological health anxiety than those treated by psychologists.[6] These effects were noted very soon after having therapy and remained highly significant 8 years later (Table 1).[7] The patients treated by nurses were also less likely to drop out of therapy and had more treatment sessions.[6]

The main point of this preliminary exercise is to assess whether the patient is likely to have health anxiety or another functional disorder. If health anxiety is suspected, the patient is better treated by psychological management with a nurse; if other functional disorders in the organ system concerned are more likely, then the generally recommended protocols (such as the Rome Foundation for gastrointestinal disorders) may be more appropriate.[8] This is because our treatments of somatic symptoms, independent of health anxiety, are relatively ineffective. They tend to concentrate on symptom reattribution, and this has not been shown to be of much value.[9] There is, of course, no reason why the physician should not act alone in assessing the functional disorder provided that adequate time is available, but this seldom appears to be the case (Table 2).

Maximising the value of the medical and nursing interview

Assuming that some form of separate assessment does take place, a decision will need to be made about the degree of confidence in the diagnosis. Bearing in mind that almost every patient will want a convincing explanation for their symptoms and, in the case of health anxiety, good reasons why investigations should not continue, the change has to be made sensitively. The angry questions (variations of 'Are you saying it's all in my mind?' and 'Are you accusing me of making this up?') have to be anticipated.

Table 1. Mean differences in improvement from baseline in scores on the Short Health Anxiety Inventory in patients with health anxiety in medical clinics, randomised to cognitive behavioural therapy or standard care; results shown for nurse therapists, psychologists and other (graduate) therapists over 8 years[6,7]

Comparison by therapist type	Difference	95% confidence interval	Probability
Nurses vs standard care at 3 months	3.77	0.33–7.20	0.0316
Nurses vs standard care at 6 months	8.45	4.99–11.90	<0.0001
Nurses vs standard care at 12 months	4.42	0.90–7.94	0.0139
Nurses vs standard care at 24 months	4.16	0.60–7.72	0.0221
Nurses vs standard care at 60 months	7.90	3.98–11.81	<0.0001
Nurses vs standard care at 96 months	9.24	4.72–13.76	<0.0001
Nurses versus other therapists at 3 months	3.67	−0.53–7.88	0.0869
Nurses versus other therapists at 6 months	3.80	−0.52–8.12	0.0848
Nurses versus other therapists at 12 months	3.18	−1.11–7.48	0.1461
Nurses versus other therapists at 24 months	1.96	−2.43–6.35	0.3809
Nurses versus other therapists at 60 months	6.40	1.60–11.20	0.0091
Nurses versus other therapists at 96 months	9.64	4.27–15.02	0.0005
Assistant psychologists vs standard care at all times	3.61	0.48–6.73	0.0239
Graduates vs standard care at all times	−0.51	−4.68–3.66	0.8088
Nurses vs standard care at all times	6.32	3.64–9.01	<0.0001
Nurses vs other therapists at all times	4.78	1.50–8.05	0.0043

A score on the SHAI indicates pathological health anxiety if the total is 20 or more; a score of 10 is normal as all should have some concern over their health. The difference of 9.6 points at 96 months between nurse therapists and others shows both the success and persistence of the therapy.
Reproduced with permission from Tyrer P, Wang D, Crawford M ***et al***. Sustained benefit of cognitive behaviour therapy for health anxiety in medical patients (CHAMP) over 8 years: a randomised-controlled trial. ***Psychol Med*** 2020 [Epub ahead of print]..

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Table 2. Response to initial assessment

Initial assessment impression	Intervention
History and examination suggests possible organic pathology	Carry out appropriate tests and other investigations
History and examination suggests organic pathology is unlikely but cannot be ruled out	Explain the reason for tests and investigations but also follow this up with nurse interview
History and examination finds no suggestion of organic pathology	Explain reluctance to investigate further followed by nurse interview

Explanations should be couched in neutral expressions such as:

I am pleased to be able to tell you that we have found nothing out of order with our tests but recognise that you still have disturbing symptoms. We need a little more time to explore these symptoms and find out there are any contributory factors we have missed. I would like you to see my colleague in the department who has more time to discuss this.

At this time the nurse should be introduced.

Health anxiety can be identified by three probe questions, best asked by the physician:

Have you been worrying a lot about this? Do you tend to worry about your health in general? Do you think that you have a more serious condition than doctors have thought or found?[10]

A clearly positive response to any of these questions should lead to the presumption of health anxiety if other investigations are negative. Negative responses to these questions, especially ones such as 'No, I just want these awful symptoms to be taken away,' suggest a more typical functional disorder that may be managed according to current guidance.[11] But even if the initial assessment suggests that health anxiety may not be present, it is always important to keep the possibility under review. In gastroenterology, there is a particular concern that cyberchondria (excessive browsing of the internet) may be responsible for an increase in health anxiety in this population.[12]

Action after initial interview

If the initial assessment leaves the physician and nurse in doubt about possible pathology, the appropriate investigations follow. If these are negative then it should be explained that further exploration of the problem is required.

Role of clinical support nurse

The separate interview with the nurse should start by asking the patient for a full account of their problems, and this should be listened to and noted carefully, even if it is long and repetitive. Patients with functional disorders are often very exact about timelines, severity and location of symptoms, and all these should be taken seriously. If the patient asks for further tests that are felt to be unnecessary, particularly complex ones like magnetic resonance imaging, please explain why these are not being recommended. At this point, it is worth mentioning that tests can sometimes be misleading and can reinforce the idea that 'the doctor wouldn't have done this test if he didn't think something was wrong.'

The role of the support nurse in functional disorders consists of listening, testing and guiding (the last part being a therapeutic role that may continue for more than one session). The listening component is very important. Patients with these disorders are often prematurely cut short and they then feel that important information is being missed. Allowing a full exposition of these concerns is of therapeutic value in itself. The key symptoms should be noted, even if at first there seems little to be gained by getting so much detail.

Testing involves deciding if the presenting problem is one of health anxiety or bodily distress, getting the symptoms into context and finding patterns to them. During the interview, it is essential to reach a formulation about the patient's deepest worries about an undiagnosed illness (health anxiety) or the worst consequences of their symptoms (bodily distress disorder). It is useful to find out which symptoms are the most pronounced, how much they change over time, and what factors accentuate of reduce them? Asking the patient to keep a diary of the intensity of a symptom and its context can often yield valuable insights.[13] For example, the weekly diary of a person with recurrent chest pain thought to be non-cardiac in origin noted that the pain was always worse on a Monday morning before an executive meeting and least at the weekend when he was carrying out vigorous tasks in the garden. Interpreting these findings guides understanding.

Guiding is a gentle nudge towards alternative explanations for symptoms that are not automatically based on physical pathology.

Explaining functional disorders to patients

The interview with the patient has to be constructed in such a way that the following outcomes are achieved.

- The validity of the patient's symptoms is acknowledged – the symptoms are real even though a physical cause may be highly unlikely.
- Sufficient collaboration has been established with the patient to lead them to consideration that an alternative explanation of their symptoms is possible in the case of health anxiety.

Almost invariably, the patient will have a series of questions to ask about the interview and the doctor's words will be given special weight, particularly if they are conditional or ambiguous. In responding to these, the doctor (or nurse) should be aware of the possible ways in which the patient's doubts may be reinforced (Table 3).

Why reassurance seldom works

The attraction of reassurance is that it seems to work, but its effects do not last. It may seem an exaggeration, but reassurance in these situations has all the properties of an addictive drug. It makes people feel better immediately but it seldom lasts for more than a few hours. Because relief from the symptoms is so valued, more and more doses of reassurance are demanded, and if the most powerful source (the consultant) is not available,

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Table 3. Reasons why blanket statements about functional disorders may often be counter-productive

Inappropriate explanation or action	Negative beliefs and consequences
I will just repeat this test to reassure you	The doctor would not have repeated this if he was convinced nothing was wrong
You have no heart/lung/brain/other disease	The absence of negative results does not take the problem away from the discipline and can be interpreted by the patient as the doctor believing the symptom is made up
The tests show you are completely well	An obvious mistake – but any comment suggesting the symptoms are not serious will be badly received
There is no evidence that anything is seriously wrong	The patient concludes that they must therefore try harder to find the evidence from other sources
Is everything all right at home?	Any comment suggesting that the problem is all in the mind will lead to an angry response

any other source will do. So, relatives and other lay people are asked persistently to reinforce the positive feelings. But, like all addictions, these interventions become less effective over time as tolerance develops.

One of the main reasons why the distinction between health anxiety and other functional disorders is so important is that once health anxiety has been established as the main problem, reassurance is completely contradicted. There is no reason why this analogy with addiction should not be given to the patient if there are continuing demands to be reassured.

Psychological treatments

Psychological treatments should be available for patients with functional disorders in medical settings before considering psychiatric referral. We have argued above that, because functional disorders are so common in medical clinics, it would never be possible to satisfy the clinical need by external referral and clinical support nurses can be trained to provide most of the psychological treatments that may be of benefit, including cognitive behavioural therapy and mindfulness training.

The great advantage of having a support nurse working in the clinic is that care is then seen as part of a continuous process, not as a disruption to another specialty.

Psychiatric input

This is discussed in detail elsewhere, however, generally, a dedicated consultant liaison service and collaborative screening of patients result in higher referral rates, probably because such services increase awareness.[13] Suicidal patients are usually quickly referred, as are as psychotic patients, but those with functional disorders are much less swiftly referred. Patients with functional disorders often end up being prescribed multiple psychotropic medications and it is often helpful to rationalise these, sometimes with the help of both psychiatrist and pharmacist. There is also some evidence that psychiatry liaison services that focus on functional disorders are cost effective and associated with high levels of patient and staff satisfaction.[14]

Follow-up

Whatever input is given in secondary care, it should be recognised that the management of almost all functional disorders will be carried out in primary care. It is therefore very important that the general practitioner receives the right kind of information in the discharge letter from the clinic which, as a matter of course, will be copied to the patient. This should include why the diagnosis of a functional disorder has been made; how the patient received the diagnosis and their reactions; if any form of psychological treatment has been given or planned; and under what circumstances would a re-referral to the clinic be justified.

Conclusion

The successful management of functional disorders needs more than a superlative physician. Time and sophistication are needed to achieve good identification and management. It is recommended that clinical support nurses with appropriate skills within medical clinics should be part of good practice and so provide the seamless care that we all desire. ■

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